DEPARTMENT OF COMMERCE
Bureau of the Census

SEP 14 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30068

Registration District No. 757 Primary Registration District No. 3036 Registrar's No. 134

1. PLACE OF DEATH:

(a) County St. Charles

(b) City or town St. Charles (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Seven weeks (Specify whether years, months or days)

In this community 57 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles

(c) City or town St. Charles (If outside city or town limits, write "RURAL")

(d) Street No. 424 N. Second St. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME John Kuechler 246

3. (b) If veteran, name war ✓

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Emma Kuechler (Hackman)

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased May (Month) 12 (Day) 1864 (Year)

8. AGE: Years 75 Months 3 Days 17 If less than one day ..... hr. ..... min.

9. Birthplace Germany (City, town, or county) ..... (State or foreign country)

10. Usual occupation Proprietor

11. Industry or business Grocery

MOTHER FATHER

12. Name John Kuechler

13. Birthplace Germany (City, town, or county) ..... (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown (City, town, or county) ..... (State or foreign country)

16. (a) Informant's own signature Elva Kuechler

(b) Address St. Charles, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21-1939 (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery, St. Charles Mo.

18. (a) Signature of funeral director H. C. Dallmeyer & Sons

(b) Address 800 N. Second, St. Charles, Mo.

19. (a) 8-21-39 (Date received local registrar) (b) Clarence G. Wessler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 19 year 1939 hour 11 minute 55 A.M.

21. I hereby certify that I attended the deceased from July 10, 1939, to Aug-19, 1939 that I last saw him alive on Aug-19, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia — Duration 5 days

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) Had a fracture of left hip

Major findings:

Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature T. C. Hopkins (M. D. or other)

Address 123 N. Main St. Charles Mo. Date signed 8-30-39

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

(Licensed Embalmer's Statement on Reverse Side)

194 b
91

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

30068
Do not use this space.

1. PLACE OF DEATH
(a) County St Charles
(b) Township
(c) City St Charles
Registration District No. 757
Primary Registration District No. 3036
Registered No. 134
(d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Kuechler
(a) Residence, No. ..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	3	17	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8 - 19 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	

Other contributory causes of importance:
Had a fractured left hip

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19.....
Where did injury occur? At home due to a fall
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) O. L. Hershman, M. D.
(Address) St Charles Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. .....

(b) Township ..... Primary Registration District No. ..... Registered No. .....

(c) City ..... (d) Street No. ..... St.

(e) Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. (f) How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If death occurred in Hospital or Institution, write its name instead of street and number)

2. PRINT FULL NAME .....

(a) Residence, No. ..... St. ..... (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. .....

9. Industry or business in which work was done, as saw mill, bank, etc. .....

10. Date discontinued last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 19

22. I HEREBY CERTIFY, That I attended deceased from ..... 19 ..... to 19

I last saw him alive on ..... 19 ..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....

What is it confirmed clinically? ..... Was there an autopsy?

23. If death was due to external cause (violence), fill in as to the following:

Accident, suicide, or homicide? ..... Date of injury 19

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) ..... M. D.

(Address) .....

Certificate of Death — Missouri State Board of Health, Bureau of Vital Statistics. Exact statement of occupation is very important.

Cause of death in plain terms so that it may be properly classified. Exact statement of occupation is very important.